FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA George Wellbeing Center
Acupuncture Foundation Session

First _____ M.I. _____ Last _____

Birthdate ____/____/____ ☐ I am 18 Years of age or older Date _____

PURPOSE

What are the main health concerns for which you are seeking care?

What are your particular goals and expectations of care? Please explain:

STRESS

Rate your level of chronic stress (10 = high) Low 1 2 3 4 5 6 7 8 9 10 High

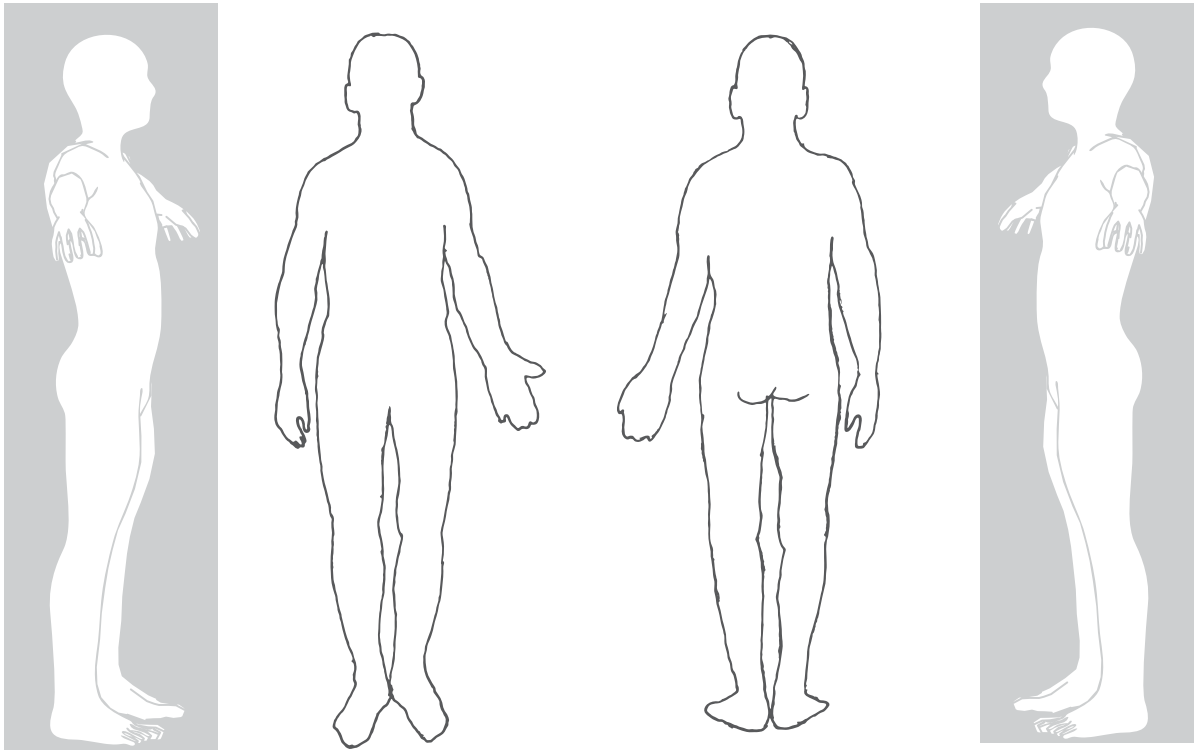
In what areas of your life do you have significant stress? (work, family, or another area)

If applicable, how has chronic stress affected your health?

☐ Anxiety ☐ Muscle tension ☐ Insomnia ☐ Irritability ☐ Other _____

Please indicate where you have pain, discomfort or other symptoms below:

KEY	
Numbness	═══
Pins & Needles	00000
Burning	XXXXX
Stabbing	/////
Aching	┼┼┼┼┼
Other	*****



19-HR05-3

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HEALTH HISTORY

Please check any of the following condition(s) that CURRENTLY applies to you:

- ☐ Fever
- ☐ Eczema or psoriasis
- ☐ Cardiovascular Disease
- ☐ Fibromyalgia
- ☐ Anxiety
- ☐ Osteoporosis
- ☐ High or low blood pressure
- ☐ Varicose veins
- ☐ Other _____
- ☐ Infectious/communicable skin disease
- ☐ Cancer
- ☐ Chronic Lung Disease
- ☐ Low back pain
- ☐ Recent trauma (accident, fall)
- ☐ Arthritis
- ☐ Headache/migraine
- ☐ Insomnia/difficulty sleeping
- ☐ Common cold symptoms
- ☐ Lymphoma
- ☐ Liver Disease
- ☐ Depression
- ☐ Dizziness/vertigo
- ☐ Stroke
- ☐ Constipation
- ☐ Pacemaker
- ☐ Allergies/intolerances/sensitivities (please list)
- ☐ Open sore/wound/ulceration
- ☐ Diabetes
- ☐ Digestion (IBS, Chrones, etc)
- ☐ Mental health
- ☐ Hypertension
- ☐ Seizure
- ☐ Cold hands and feet
- ☐ Heart palpitations

Please explain any condition(s) that you have marked:

Have you experienced any of these conditions in the PAST, but not currently? ☐ Yes ☐ No If yes, please explain.

Have you experienced any significant illnesses, traumas, accidents, surgeries, or hospitalizations? ☐ Yes ☐ No If yes, please describe WITH dates.

Are you currently taking any prescription medications? ☐ Yes ☐ No Medicinal herbs? ☐ Yes ☐ No Supplements? ☐ Yes ☐ No
If yes, please list (name and dosage).

PEOPLE WHO HAVE OR HAD A UTERUS

Are you pregnant? ☐ Yes ☐ No Are you currently trying to become pregnant? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No If yes, Number of miscarriages/still born/terminations _____

Number of full term pregnancies _____

Have you transitioned into menopause? ☐ Yes ☐ No If yes, age range of menopause _____

Number of days of menstrual cycle (i.e. 28-45 days): _____ Number of days of menses: _____

First day of last menses: _____ Last day of last menses: _____

Any blood clots? If yes, what is the color? ☐ Bright Red ☐ Brown ☐ Dark Red/Purple

If yes, size of blood clots ☐ Dime ☐ Nickel ☐ Quarter

If you experience pain before, after or during menses, please describe the pain: ☐ Stabbing ☐ Burning ☐ Aching ☐ Dull

☐ Bloating ☐ Cramping ☐ Other _____

When do you experience the pain? ☐ Before menses ☐ During menses ☐ After menses

Where do you experience the pain? ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other _____

PEOPLE WHO HAVE OR HAD A PROSTATE

Any symptoms related to prostate? Check all that apply

☐ Benign Prostatic Hyperplasia/Enlarged prostate ☐ Back pain ☐ Urinary dribbling ☐ Frequent urination

☐ Difficulty urinating ☐ Retention of urine ☐ Delayed urine stream ☐ Incontinence ☐ Rectal dysfunction

☐ Impotence/Erectile Dysfunction ☐ Testicular pain ☐ Other _____

IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO SHARE WITH YOUR PROVIDER?

Client Signature _____ Date _____

Parent/Guardian Name _____
(please print)

Parent/Guardian Signature _____ Date _____